# Adult Medical History

Primary physician: _____Physician's phone number:_____

Are you currently under a doctor's care? ..... Yes / No

If yes, please explain:_____

Have you been hospitalized or had any surgeries in the last 5 years? ..... Yes / No

If yes, please explain:_____

Have you had any unfavorable reaction following dental treatment? ..... Yes / No

If yes, please explain:_____

Are you allergic sensitive or allergic to:

| | | |
|---|---|---|
| ☐ Penicillin | ☐ Erythromycin | ☐ Latex |
| ☐ Codeine | ☐ Sulfa Drugs | ☐ Sedatives |
| ☐ Tetracycline | ☐ Metals | ☐ Dental Anesthetics |

List allergen and describe reaction: _____

Are you allergic to any other medications, drugs or treatments? …….. Yes / No

If yes, please explain: _____

Are you taking or have you in the past twelve years taken any bisphosphonate medications? ……Yes / No

If yes, how long: _____ please indicate which medication: ☐ Actonel ☐ Fosamax ☐ Zometa ☐ Other

If other, please list medication: _____

Are you currently taking any prescription or non-prescription medications?.....Yes / No

Medication Dose/Frequency Reason for taking

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Do you use tobacco? Yes / No Packs / cans per day: _____ # of years: _____

Do you use alcohol? Yes / No How often? _____

**(Continued)**

Medical Conditions

Do you have or have you had any of the following diseases or problems? Mark all that apply.

- ☐ AIDS / HIV
- ☐ Abnormal Bleeding
- ☐ Alcohol Addiction
- ☐ Alzheimer's or Dementia
- ☐ Anemia
- ☐ Arthritis / Gout
- ☐ Artificial Pins: Bones or Joints
  When: _____
  Where: _____
- ☐ Artificial Heart Valve
- ☐ Asthma
- ☐ Blood Disease
- ☐ Blood Thinners
- ☐ Blood Transfusion
- ☐ Cancer / Tumors
  List Type: _____
- ☐ Chemotherapy
- ☐ Chest Pains
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Colitis
- ☐ Congenital Heart Defect
- ☐ Diabetes
  Type: _____
- ☐ Difficulty Breathing
- ☐ Drug Addiction
- ☐ Emphysema
- ☐ Epilepsy or Seizures
- ☐ Fainting or Dizzy Spells
- ☐ GERD or Reflux
- ☐ Glaucoma
- ☐ Hay Fever
- ☐ Headaches
- ☐ Hearing Problem
- ☐ Heart Attack
  Date: _____
- ☐ Heart Disease
- ☐ Heart Murmur
- ☐ Heart Surgery
  Type of Surgery: _____
- ☐ Heart Trouble
- ☐ Hemophilia
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Mitral Valve Prolapse
- ☐ Neurological Disorders
  Disorder: _____
- ☐ Osteoporosis
- ☐ Pacemaker
  Date Placed: _____
  Type Placed: _____
- ☐ Persistent Cough
- ☐ Psychiatric Problems
- ☐ Radiation Therapy
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Seizure Disorder
- ☐ Sexually Transmitted Disease
- ☐ Shingles
- ☐ Shortness of Breath
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Stroke/ CVA
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other

Women only:
Are you or could you be pregnant? Yes / No Due date: _____

Please list any serious medical condition(s) not indicated above that you have experienced in the last 5 years

_____

_____

_____

Emergency Contact: _____ Phone: _____ Relationship: _____

By signing this form, I acknowledge that the information provided is true and accurate to the best of my knowledge.

_____ _____
Patient Signature Date